HMO PLUS Benefit Summary

Physicians Health Plan

Plan DPL16114

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
ANNUAL DEDUCTIBLE	$125 per individual/$250 per family	$300 per individual/$600 per family
ANNUAL OUT-OF-POCKET MAXIMUM (includes deductible, coinsurance, copays)	$2,000 per individual/$4,000 per family	$3,300 per individual/$6,600 per family
PLAN YEAR	October 12, 2014 through October 11, 2015	
This Benefit plan does not contain an annual or lifetime limit on the dollar amount of Essential Health Benefits.		
	AMOUNT COVERED	**AMOUNT COVERED**
PHYSICIAN OFFICE VISITS		
Office visits for illness or injury	100% after $20/visit, deductible waived	80% of Eligible Expenses (EE) after deductible
Injections/infusions	Covered 100%	80% of EE after deductible
Allergy testing and treatment	100% after deductible	80% of EE after deductible
PREVENTIVE SERVICES		
Including but not limited to: • Physical exams • Well baby and well child care • Immunizations • Routine eye exam – *limit of 1 exam/CY* • Routine mammography • Nutritional counseling – *limit of 3 sessions/CY*	Covered 100%	Not covered
INPATIENT HOSPITAL		
Unlimited days in a semi-private room, special care units, necessary ancillary hospital services, surgery and related services, anesthesia and its administration, physician services including consultation	100% after deductible	80% of EE after deductible
Transplant services (at designated facilities)	100% after deductible	Not covered
OUTPATIENT HOSPITAL		
Female surgical sterilization and related services	Covered 100%	80% of EE after deductible
All other surgery and related services	100% after deductible	80% of EE after deductible
Diagnostic laboratory testing/pathology	Covered 100%	80% of EE after deductible
Diagnostic X-ray, advanced imaging and nuclear medicine	100% after deductible	80% of EE after deductible
Diagnostic services (such as certain endoscopic and cardiac procedures and therapeutic treatments)	100% after deductible	80% of EE after deductible
EMERGENCY/URGENT SERVICES		
At hospital emergency department	Covered 100%, $200/visit if not admitted	Same as Network benefit
At urgent care facility (after hour services)	100% after $20/visit, deductible waived	Same as Network benefit
At non-network physician's office outside the service area	100% after $20/visit, deductible waived	Same as Network benefit
BEHAVIORAL HEALTH SERVICES		
Inpatient treatment (including detoxification)	100% after deductible	80% of EE after deductible
Intermediate treatment (including residential treatment program for substance use disorders)	100% after deductible	80% of EE after deductible
Outpatient therapy visits and testing for mental health conditions	100% after $20/visit, deductible waived	80% of EE after deductible
All other outpatient items and services	Covered 100%	80% of EE after deductible

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TYPE OF BENEFITS	NETWORK BENEFITS AMOUNT COVERED	NON-NETWORK BENEFITS AMOUNT COVERED
OTHER SERVICES		
Home health care	100% after $20/visit after deductible *Combined network and non-network benefits limited to 60 visits per CY*	80% of EE after deductible
Skilled nursing facility/ inpatient rehabilitation facility	100% after deductible *Combined network and non-network benefits limited to 120 days per CY*	80% of EE after deductible
Maternity care (prenatal, delivery and postnatal services)	Covered 100%	80% of EE after deductible
Hospice care	100% after deductible	80% of EE after deductible
Ambulance services	100% after deductible	Same as Network benefit
Prosthetic devices	Covered 100%	80% of EE after deductible
Durable medical equipment	Covered 100%	80% of EE after deductible
Outpatient rehabilitation therapy	100% after $20/visit, deductible waived *Combined network and non-network limitations apply*	80% of EE after deductible
Infertility treatment (to treat the conditions that result in infertility)	100% after deductible *Limited to 5 office visits and 3 diagnostic or surgical procedures per CY*	Not covered
Chiropractic services	100% after $20/visit after deductible *Limited to 20 visits per CY*	Not covered
Tobacco cessation program	Covered 100%	Not covered
Autism Spectrum Disorders treatment (for children from birth through age 18)	ABA: 100% after deductible OP rehabiliation therapy: 100% after $20/visit, deductible waived *ABA limited to 930 hours per CY*	Not covered
Hearing aids	Covered 100% *Limited to either one monaural to a maximum benefit of $880 or one binaural to a maximum of $1600; every 36 months*	Not covered
Laser eye surgery	Covered 100% *Limited to $755 for both eyes per lifetime*	

Certain services must be authorized in advance to receive full coverage. Failure to obtain prior authorization when required may result in reduced or no benefit. Complete details are found in your PHP Certificate of Coverage. Covered Health Services must be Medically Necessary as determined by PHP medical policy and nationally recognized guidelines. Member materials, including the PHP Certificate of Coverage, can be found online at our Member Reference Desk. Members may access the Member Reference Desk through our web site at www.phpmichigan.com.

NOTE: This policy is not subject to a pre-existing condition limitation.

Except as may be specifically provided through a Rider to the policy, exclusions include:

- Routine dental care
- Cosmetic surgery
- Hearing aids and services
- Vision hardware
- Custodial care, bed care, convenience care, day care, domiciliary care
- Experimental or investigational procedures or services

For additional information about exclusions and limitations, visit our web site, or contact the PHP Customer Service Department to review the PHP Certificate of Coverage for this benefit plan. This Summary of Benefits is intended only to highlight the benefits provided under HMO PLUS and should not be relied upon to fully determine coverage. This health plan may not cover all health care expenses. Please refer to the PHP Certificate of Coverage for a complete listing of covered services, limitations and exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the policy issued to the enrolling group, the policy will prevail. For answers to questions about information, which appears in the summary, call our Customer Service Department at 517.364.8500 or 800.832.9186.

Important Notice on Patient Protection Provisions Included in Your Plan as Part of the Affordable Care Act

If you wish to receive Network Benefits, you must select a Primary Care Physician from our list of participating providers who are available to accept you or your family members to coordinate your health care services. This helps ensure continuity of care and provides you and your Dependents with a medical home. If you are the custodial parent of an Enrolled Dependent child, you must select a Primary Care Physician for that child. Your child's PCP may be a Network pediatrician. You do not need authorization from us or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a Network Provider who specializes in obstetrics or gynecology. However, the Network provider may be required to obtain authorization prior to certain services, which are listed in your Certificate of Coverage. Your Plan covers Emergency Health Services in any hospital emergency department. Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Health Services at a Non-Network facility. However, a Non-Network provider may send you a bill for any charges remaining after your Plan has paid.